MassHealth

March 2006

MassHealth and the New ADA Claim Form

The MassHealth Dental Program is currently in a pilot phase with selected providers for accepting the ADA claim form. Effective July 1, 2006, versions 2002 and 2004 of the ADA claim form will be the only paper claim forms that we will accept for dental services. We plan to roll out the use of the ADA claim form for all dental providers in the spring of 2006. We will notify you by printing a message on remittance advices and by bulletin or transmittal letter, when, prior to July 1, 2006, you can begin submitting claims using the ADA Dental claim form. During this transition period, we will accept and process claims for dental services on either the MassHealth claim form no. 11 or the ADA Dental Claim Form versions 2002 and 2004. However, we will no longer be able to accept MassHealth claim form no. 11 after June 30, 2006.

If you have questions or concerns about the MassHealth Dental Program, please contact our **Customer Service Center** at 1-800-841-2900 or e-mail providersupport@mahealth.net for more information.

The completion requirements for the ADA Claim Form for MassHealth are **primarily the same as those for other payers**. However, there will be some requirements that are specific to MassHealth. These unique requirements are listed below.

1. Information for MassHealth adjustment and resubmittal claims must be entered in Field 35, “Remarks,” of the ADA Claim Form. For MassHealth resubmittals that require a transaction control number (TCN) (see All Provider Bulletin 123, dated May 2003), enter R followed by the 10-character TCN assigned to the original claim. For MassHealth adjustments, enter A followed by the 10-character TCN assigned to the most recently paid claim. Do not enter any other information in Field 35.
2. Field 1b, “Request for Predetermination/Preauthorization”, should always be left blank. MassHealth does not use this form for prior-authorization requests.
3. Tooth quadrant codes for MassHealth will be limited to the following four quadrant codes: 10, 20, 30, and 40. These are HIPAA-compliant indicators for quadrants.
4. Use Field 16, "Plan/Group Number," to report the billing agent number, if applicable.
5. If the member has other insurance, please ensure that all the following conditions are met:
   - an explanation of benefits (EOB) is attached to the claim;
   - the payments on the EOB are itemized and correspond to the claim you are submitting to MassHealth;
   - the lines on the EOB are numbered to match with the corresponding lines on the ADA claim form (this may require you to annotate the EOB with a number that corresponds to the claim line on the ADA claim form);
   - if the procedure codes on the EOB differ from the procedure codes on the claim, annotate on the EOB how they differ; and
   - the “Yes” box in Field # 4, “Other Dental or Medical Coverage?”, of the claim form is checked.

Please see the attached field-by-field instructions on how to complete the ADA Claim Form.

Draft Instructions for Completing the ADA 2002 and 2004 Claim Forms for MassHealth

In spring 2006, an announcement will be posted in the "News & Updates" box on www.mass.gov/masshealth to inform you of when you can start submitting the ADA 2002 or 2004 claim form. We will also issue remittance advice messages, transmittal letters, and provider bulletins to keep you up to date with this transition.

NOTE: MassHealth will stop accepting claim form no. 11 on June 30, 2006.

Version History

Version	Author	Content
11/3/05	**MC**	This document was created in order to aid software vendors and the dental provider community in updating their software to be compliant with MassHealth billing regulations for the ADA claim form. The original document was distributed to the software vendor community, and subsequently to the providers participating in the MassHealth ADA Claim Form Pilot.
1/18/06	**MC**	Updates to the document cover page and removal of confusing instructions regarding the size of the paper claim.
2/27/2006	**MC**	Updates to the cover page and the ways that the EOB information needs to correspond specifically to the claim form.
3/3/2006	**MC**	Updated cover page to include information on billing agent number and made Field 4 required.
3/16/2006	**JC**	Updated the instructions and the cover page to mirror the language in the MassHealth bulletin on the ADA claim form.

Purpose of This Document

This document was created for MassHealth providers by MassHealth to supplement the ADA Claim Form 2002 and 2004 instructions. It contains MassHealth-specific instructions for completing the ADA Claim Form 2002 and 2004. It is intended to allow all dental providers to assess their software system capabilities and required changes to support submitting claims for dental services to MassHealth on the paper ADA Claim Form 2002 and 2004. The information in this document in no way supersedes MassHealth's regulations and this document should be used in conjunction with the information found in the MassHealth *Dental Manual*.

Eventually, these instructions will be reissued in a more comprehensive guide.

Intended Audience

The intended audience for this document is the technical staff responsible for updating provider billing systems that will print paper ADA Claim Forms 2002 and 2004 for submission to MassHealth. In addition, this information should be shared with the provider's billing office to ensure all required billing information is available for claim submission.

Contact Information

If you have questions or concerns about the MassHealth Dental Program or submitting claims to MassHealth using the ADA Claim Form 2002 and 2004, please contact our **Customer Service Center** at 1-800-841-2900 or e-mail providersupport@mahealth.net.

Field	Description	Instructions for Completion	Directions
Header Information			
1	Dentist's Statement of Actual Services	Always enter an X in this box for a MassHealth claim.	REQUIRED FIELD
	Request for Predetermination/ Preauthorization	MassHealth does not use this field. For instructions on requesting prior authorization (PA), please refer to Subchapter 5 of the *Dental Manual* and MassHealth PA regulations in Subchapter 4 of the *Dental Manual*. This form is not used to request PA.	LEAVE BLANK
	EPSDT/Title XIX	Enter an X in this box if the patient was referred for dental services as a result of an EPSDT medical screening.	CONDITIONAL FIELD
2	Predetermination/ Preauthorization Number	If billing for a service for which PA is required, enter the six-digit PA number assigned by MassHealth. If there are multiple PA numbers, use a separate claim for each separate PA number.	CONDITIONAL FIELD
Primary Payer Information			
3	Name, Address, City, State, Zip Code		OPTIONAL FIELD
Other Coverage			
4	Other Dental or Medical Coverage?	If the member has dental coverage in addition to MassHealth, • check Yes; • attach a copy of the explanation of benefits (EOB) from that insurer; and • itemize all payments on the EOB. Completing the ADA service lines in the same order as they appear on the EOB will expedite the claim entry process. If there is a different code or a different method used for payment by the other insurance, explain the conversion to MassHealth on the EOB. For example, if the primary payer uses D1201 to indicate a fluoride treatment and prophylaxis, report the distribution of payment as D1120 and D1203.	REQUIRED FIELD

Field	Description	Instructions for Completion	Directions
		If the member has other medical insurance, but it does not cover dental services or if the member has no other insurance, check No and skip to Field 12.	
5	Other Insured's Name		OPTIONAL FIELD
6	Date of Birth		OPTIONAL FIELD
7	Gender		OPTIONAL FIELD
8	Subscriber Identifier (SSN or ID#)		OPTIONAL FIELD
9	Plan/Group Number		OPTIONAL FIELD
10	Patient's Relationship to Other Insured (Check applicable box)		OPTIONAL FIELD
11	Other Carrier Name, Address, City, State, Zip Code		OPTIONAL FIELD
Primary Insured Information			
12	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the member's complete name, address, and zip code.	REQUIRED FIELD
13	Date of Birth (MM/DD/CCYY)	Enter the member's date of birth in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY.	REQUIRED FIELD
14	Gender	Enter the member's gender.	REQUIRED FIELD
15	Subscriber Identifier (SSN or ID #)	Enter the member's 10-character MassHealth identification number.	REQUIRED FIELD
16	Plan/Group Number	If this form is being prepared by a billing intermediary, enter the seven-digit number assigned to the billing agency by MassHealth** ***Only those intermediaries who also submit electronic claims to MassHealth will have a number.*	OPTIONAL FIELD
17	Employer Name		OPTIONAL FIELD
Patient Information			
18	Relationship to Primary Insured (Check applicable box)		OPTIONAL FIELD
19	Student Status		OPTIONAL FIELD

Field	Description	Instructions for Completion	Directions
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	If completed, enter the information as it appears in Field 12.	OPTIONAL FIELD
21	Date of Birth (MM/DD/CCYY)	If completed, enter the information as it appears in Field 13. Enter the information in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY.	OPTIONAL FIELD
22	Gender	If completed, enter the information as it appears in Field 14.	OPTIONAL FIELD
23	Patient ID/ Account # (Assigned by Dentist)	If the dental office has assigned a number to identify the patient, enter it here.	OPTIONAL FIELD. Recommended to assist the provider in identifying patients when the MassHealth identification number may have been incorrect. The maximum number of characters for this field is 10.
Record of Services Provided			
24	Procedure Date	Enter the date of service in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY.	REQUIRED FIELD
25	Area of Oral Cavity	Report the quadrant of the oral cavity in this field. Acceptable quadrant values are listed below. 10 – Upper right quadrant 20 – Upper left quadrant 30 – Lower left quadrant 40 – Lower right quadrant	CONDITIONAL FIELD
26	Tooth System		OPTIONAL FIELD

Field	Description	Instructions for Completion	Directions
27	Tooth Number(s) or Letter(s)	Enter the permanent tooth number or primary tooth letter for tooth-specific services. Acceptable tooth numbers and letters are listed below. • 1 through 32 for permanent dentition • 51 through 82 for supernumerary permanent dentition • A through T for primary dentition • Add S to primary dentition letter to indicate supernumerary teeth associated with primary dentition (for example, AS through TS).	CONDITIONAL FIELD
28	Tooth Surface	For tooth-specific services, enter the appropriate surface code. Acceptable codes are listed below. B - Buccal D - Distal) F - Facial I - Incisial L - Lingual M - Mesial O - Occlusal	CONDITIONAL FIELD
29	Procedure Code	Enter the five-character service code from Subchapter 6 of the *Dental Manual* or from Appendix E of the *Dental Manual* (for oral surgery) that describes the service provided. If billing with a service code that requires a report, attach a copy of the report to the claim form.	REQUIRED FIELD
30	Description		OPTIONAL FIELD
31	Fee	Enter the provider's usual fee (the usual charge to the general public for the same or a similar service). Do not list services for which no charge was made. All services listed in Subchapter 6 of the Dental Manual or Appendix E of the *Dental Manual* that require individual consideration also require PA, so the fee paid will be the authorized fee on the PA.	REQUIRED FIELD
32	Other Fees		LEAVE BLANK
33	Total Fee	Enter the sum of fees from all lines in Field 31.	REQUIRED FIELD

Field	Description	Instructions for Completion	Directions
Missing Teeth Information			
34	Missing Teeth Information		OPTIONAL FIELD
35	Remarks	Use this field to indicate if the claim is a resubmittal or an adjustment. For resubmittals that require a transaction control number (TCN) (see All Provider Bulletin 123, dated May 2003), enter R followed by the 10-character TCN assigned to the original claim. For adjustments, enter A followed by the 10-character TCN assigned to the most recently paid claim. The TCN appears on the remittance advice that listed the claim as paid or denied. Left-justify all information and begin text immediately following the word “Remarks.” Nothing other than resubmittal or adjustment information should be entered in this field.	CONDITIONAL FIELD
Authorizations			
36	Patient Consent		OPTIONAL FIELD
37	Insured's Signature		OPTIONAL FIELD
Ancillary Claim/Treatment Information			
38	Place of Treatment	Enter an X in the Provider's Office box if the services were performed in an office. Enter an X in the Hospital box for inpatient and outpatient hospital services. Enter an X in the ECF box if the services were performed in an extended care facility (for example, nursing facility). Enter an X in the Other box if none of the other place-of-service indicators apply (for example, school-based services). If the member received services in multiple places of service, submit a separate claim for each place of service.	REQUIRED FIELD
39	Number of Enclosures		OPTIONAL FIELD
40	Is Treatment for Orthodontics?		OPTIONAL FIELD

Field	Description	Instructions for Completion	Directions
41	Date Appliance Placed	If completed, provide the date in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY.	OPTIONAL FIELD
42	Months of Treatment Remaining		OPTIONAL FIELD
43	Replacement of Prosthesis?		OPTIONAL FIELD
44	Date Prior Placement		OPTIONAL FIELD
45	Treatment Resulting from (Check applicable box)	If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box in this field, and proceed to Field 46. If the services you are providing are not the result of an accident or injury, skip to Field 48.	CONDITIONAL FIELD
46	Date of Accident (MM/DD/CCYY)	Enter the date on which the accident or injury noted in Field 45 occurred in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY. Otherwise, leave blank.	CONDITIONAL FIELD
47	Auto Accident State		OPTIONAL FIELD
Billing Dentist or Dental Entity			
48	Name, Address, City, State, Zip Code	Enter the name and complete address of the dentist or the dental entity (corporation or group).	REQUIRED FIELD
49	Provider ID	Enter the seven-digit MassHealth pay-to-provider number. If the dental provider furnished the service as part of a group practice, enter the seven-digit provider number assigned by MassHealth to the group. Enter the seven-digit MassHealth provider number assigned to the individual dentist if payments are to be made to the individual provider.	REQUIRED FIELD
50	License Number		OPTIONAL FIELD
51	SSN or TIN		OPTIONAL FIELD
52	Phone Number		OPTIONAL FIELD

Field	Description	Instructions for Completion	Directions
Treating Dentist and Treatment Location Information			
53	Certification	Provide the signature of the treating dentist and the date the form is signed. This is the dentist who performed procedures indicated by date, for the patient. Provider signatures on the claim form may be handwritten, typed, stamped, or electronic.	REQUIRED FIELD
54	Provider ID	If the provider furnished the service as part of a group practice, enter the seven-digit MassHealth provider number assigned to the individual provider. Complete this field only if the information in this field is different from the information contained in Field 49.	CONDITIONAL FIELD
55	License Number		OPTIONAL FIELD
56	Address, City, State, Zip Code		OPTIONAL FIELD
57	Phone Number		OPTIONAL FIELD
58	Treating Provider Specialty		OPTIONAL FIELD